



ARKANSAS STATE BOARD OF NURSING DEPARTMENT OF ENFORCEMENT

CURRENT MEDICATION LIST

Please provide the following information: list all current medications that you are taking, including prescribed and over-the-counter, the dosage, the prescribing provider and contact information, and the reason for taking the medication.

| Name of Medication | Dosage | Prescribing Provider & Contact Information | Reason for Taking the Medication |
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Name: _____ Date: _____ License #: _____